

# STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State: Nevada

Attachment 4.19-D

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## PAYMENT FOR LONG TERM NURSING FACILITY SERVICES METHODS AND STANDARDS

Payment is made for services provided in nursing facilities, including nursing facilities for the mentally retarded, in accordance with Section 1902(a) (13) of the Social Security Act as amended.

A. Hospital-Based Facilities: (Hospital-based facility is defined as: a) a facility sharing a common building or common tract of land with a hospital owned or operated by the state, or an instrumentality or unit of government within the state, located within a county of a population of 100,000 or less; or b) a facility (public or private) which prior to July 1, 1992, was paid for both inpatient hospital services under Attachment 4.19-A of the Medicaid State Plan and long-term nursing facility services under this section.)

1. Hospital-based nursing facility services are paid for under Medicare reasonable cost-based reimbursement principles, including the routine cost limitation (RCL), and the lesser of cost or charges (LCC).

Effective October 1, 2001, hospital-based nursing facilities shall continue to be reimbursed under Medicare's cost based reimbursement principles, along with the other provisions of paragraphs A.2 and A.3.

Under this methodology, payment will follow any and all applicable Medicare upper payment limitation (UPL) requirements such that payments will not exceed the UPL. The rates the State of Nevada would pay per day of nursing facility care comply with the Medicare upper payment limit at 42 CFR 447.272, as amended.

The routine cost limit (RCL) used in cost settlements will be \$160.14 per day, effective October 1, 2001. This RCL will apply to cost reports ending on or after October 1, 2001, and will only apply to the portion of the cost report period on or after October 1, 2001. For those cost reports beginning prior to October 1, 2001 and ending on or after October 1, 2001, a weighted average RCL will be used. The RCL applicable to the portion of the cost report period prior to October 1, 2001 will be the per diem routine service cost paid to the facility during the most current cost report period ending prior to October 1, 2001. The RCL applicable to the portion of the cost report period on or after October 1, 2001, will be the RCL of \$160.14, as adjusted for inflation. For example: If a hospital-based facility with a June 30 year end was paid \$140 per day for routine service cost during its year ending June 30, 2001, the \$140 per day would be the RCL for this facility during the portion of the cost reporting year from July 1, 2001 through September 30, 2001. The RCL for the remainder of the year ending June 30, 2002 (October 1, 2001 through June 30, 2002) would be the \$160.14 RCL, as adjusted for inflation.

The \$160.14 RCL will be indexed (adjusted for inflation) from October 1, 2001 to the midpoint of the cost-reporting period to which it is applied. The Skilled and Intermediate Care Facilities without capital (non-seasonally adjusted) Table 9: Percent Change in Medical Prices as published by MEI will be used in indexing the RCL. If this index becomes unavailable, a comparable index will be used.

The Medicaid program will re-base the RCL every other year, beginning July 1, 2003, using audited hospital-based nursing facility cost report data, input from the hospital-based nursing facility providers, and other information deemed appropriate.

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2. In no case may payment for hospital-based nursing facility services exceed the provider's customary charges to the general public for these services.
3. Each facility will receive interim payments of the lower of 1) billed charges; or 2) an interim payment percentage that is the ratio of costs to charges from the facility's most recently audited cost report.

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B. Free-standing Nursing Facilities (Free-standing nursing facility is defined as any other facility providing nursing facility services, except hospital-based nursing facilities.):

1. Reimbursement Methodology – January 1, 2002 through June 30, 2002:

- a. In preparing the free-standing nursing facilities for a resource utilization group (RUG) based Medicaid reimbursement system, a transitional rate setting process will be adopted effective January 1, 2002. The significant elements of this system include the following:
  - b. Base operating rates will be calculated for each facility effective January 1, 2002. The base operating rates will be calculated for each free-standing nursing facility using the weighted average operating rate for each facility effective October 1, 2001, (excluding SNL-3 days and rates). The days used to prepare the weighted average operating rates will be paid nursing facility days from January 1, 2001 through June 30, 2001 (excluding SNL-3 days) as shown on a paid claims listing prepared in November 2001. Each facility's capital rate effective October 1, 2001, will be added to their weighted average operating rate. If the statewide Medicaid day weighted average operating and capital rates, calculated as described above, exceed the budget target rate of \$121.02, a budget adjustment factor will be employed to adjust the calculated rates to meet the budget target.
- c. For those facilities with unstable occupancy (i.e. facilities receiving their initial Medicaid certification on or after January 1, 2000), their base rate will be adjusted for changes in Medicaid acuity as follows:
  1. A snapshot Medicaid average case mix index (CMI) will be calculated for each facility effective October 1, 2001.
  2. Medicaid average CMIs will be prepared for these facilities as of January 1, 2002 and April 1, 2002, using the same weights as were used to prepare the October 1, 2001 snapshot.
  3. The change in average Medicaid CMI, for each unstable occupancy nursing facility as measured from October 1, 2001 to January 1, 2002, and from October 1, 2001 to April 1, 2002, will be used to proportionally increase or decrease 40% of that facility's operating rate effective January 1, 2002 and April 1, 2002.

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2. Reimbursement Methodology July 1, 2002 through June 30, 2003:

- a. Effective July 1, 2002, each nursing facility's base rate (the rate in effect for each facility on June 30, 2002) will be adjusted for the change in their average Medicaid CMI. The ratio to use in this calculation will be developed using as its numerator each facility's simple average of their Medicaid CMI as of January 1, 2002 and April 1, 2002. The denominator will be the simple average of each facility's Medicaid CMI calculated as of October 1, 2001 and January 1, 2002.
- b. The rates in 2.a. will be further acuity-adjusted quarterly. In preparing these rate adjustments, the denominator of the fraction described in item 2.a. above will remain unchanged for each facility. The numerator of the fraction for October 1, 2002 adjustment will reflect the simple average of each facility's Medicaid CMI as of April 1, 2002 and July 1, 2002. The July 2002 and October 2002 average Medicaid CMI will be used in the January 1, 2003 rate setting, while the October 2002 and January 2003 average Medicaid CMI will be used in the April 1, 2003 rate adjustments.
- c. The acuity-adjusted rates, as described above in item 2.a. and b., will be further adjusted by an adjustment factor to not exceed the industry Medicaid weighted average per patient day rate effective January 1, 2002 as described in B. 1. b. above.
- d. 40% of each facility's weighted average operating rate will be subject to the acuity adjustments described in this section.
- e. Facilities that were initially certified between July 1, 1999 and December 31, 1999, will have their rates adjusted to reflect the adjustments to rates that were made to unstable occupancy facilities during the period of January 1, 2002 through June 30, 2002. These rate adjustments will be effective July 1, 2002. The intent of this provision is to treat facilities initially certified during this period as if they had been identified as unstable occupancy facilities during the period from January 1, 2002 through June 30, 2002.

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3. Reimbursement Methodology – Effective July 1, 2003:

Effective July 1, 2003, a nursing facility price-based reimbursement system will be implemented. Individual facility rates will be developed from prices established for three separate cost centers: operating, direct health care and capital. The allowable cost used in these rate setting activities will be nursing facility health care cost determined to be allowable in accordance with the Medicare / Medicaid provider reimbursement manual, commonly referred to as HIM 15.

- a. **Operating Cost Center** – The operating cost center will be comprised of all allowable cost excluding direct care cost, capital cost and direct ancillary service cost. The statewide price for this cost center will be set at 105% of the Medicaid day weighted median.

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**Direct Health Care Cost Center** – The direct health care cost center will be comprised of allowable RN, LPN, and Nursing Aide salaries and wages; a proportionate allocation of allowable employee benefits; and the direct allowable cost of acquiring RN, LPN and Nurse Aide staff from outside staffing companies. The statewide price will be established for this cost center at 110% of the Medicaid day weighted median case mix neutralized cost. In preparing the case mix neutralization, a minimum of two calendar quarters from each facility's available quarterly facility wide case mix index information that most closely matches their base year cost report will be used to calculate the Medicaid day weighted average. On a quarterly basis, each facility's specific direct health care price is determined by adjusting the statewide price using as the numerator, the facility's most current quarterly Medicaid case mix index and as the denominator, the Medicaid day weighted average of the facility wide case mix indexes used in setting the statewide price.

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c. **Capital Cost Center** – This cost center will be comprised of allowable depreciation, capital related interest, rent / lease, and amortization expenses. A fair rental value (FRV) reimbursement system will be used to determine each facility’s capital rate. The following items will be used in determining each facility’s FRV rate:

- i. Value of New Beds (7/01/03) \$73,000.00
- ii. Bed Value Indexed Annually (using Marshall Swift, Class C nursing facility index)
- iii. Rate of Depreciation 1.5% / Year
- iv. Maximum Age 40 Years
- v. Rental Rate 9.0% Annually
- vi. Minimum Occupancy Percent 92%

These values will be used to determine a facility’s FRV payment as demonstrated below:  
(Example facility has 100 beds and is 10 years old)

Licensed Beds	100
Times Value / Bed	\$73,000
Gross Value	\$7,300,000
Depreciation Rate (1.5% x 10 Years)	15%
Depreciated Value (85%)	\$6,205,000
Rental Rate	9%
FRV Payment (Gross)	\$558,450
Divided by Greater of Actual or Minimum Days	33,580
Fair Rental Value Payment	\$16.63

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- 1) **Capital Renovations / Remodeling Projects** – The fair rental value of each facility will be adjusted (increased) to reflect the cost of major renovation / replacement projects completed by each facility not to exceed a 24-month period. The renovation / replacement adjustment would be made at the start of the first rate year following completion of the renovation / replacement project.

The cost of renovation / replacement projects must be documented within each facility's depreciation schedule, must be reported to the Medicaid program by May 1<sup>st</sup> prior to the July 1<sup>st</sup> rate year when they would first be eligible for incorporation into the FRV rate setting process, and must exceed \$1,000.00 per licensed bed in order to be considered a major renovation / replacement. The cost of these renovation / replacement projects will be depreciated at a rate of 4% per year, but will also be indexed (inflated) annually using the bed value indexing methodology incorporated into this fair rental value system.

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- 2) **Initial Age of Nevada Nursing Facilities for July 1, 2003 FRV Calculations** – The initial age for each facility shall be determined as of July 1, 2003, using each facility's year of construction. This age will be reduced for renovations and/or additions of beds that have occurred since the facility was built. If a facility added beds, these new beds will be averaged in with the original beds and a weighted average age for all beds will be used as the initial age. If a facility performed a major renovation project between the time the facility was built and the time when the initial age is determined, the cost of the renovation project will be used to determine the equivalent number of new beds that project represents. The equivalent number of new beds would then be used to determine the weighted average age of all beds for this facility. The equivalent number of new beds from a renovation project will be determined by dividing the cost of the renovation project by the cost of a new bed (using the new bed valuation methodology incorporated into the FRV system) at the time the renovation project was completed. Facility ages will be rounded to the nearest whole number.

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- d. **Inflation Factor Used in Rate Setting** – When establishing the medians for the operating and direct health care cost centers, cost will be adjusted from the midpoint of each provider’s base year cost report to the midpoint of each state fiscal year using the Nursing Home Services without capital (non-seasonally adjusted Table 9: Percent Change in Medical Prices) as published by MEI. If this index becomes unavailable, a comparable index will be used. In non-rebasing years, the Medians from the most recent rebasing period will be indexed forward to the midpoint of the current rate year using this indexing methodology.

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- e. **Base Year Cost Report (July 1, 2003 Rate Year) and Rebasing Frequency** – Cost reports used to establish the July 1, 2003 operating and direct care medians, and ultimate prices, will be the most current cost report for each facility whose audit or desk review was completed at least three (3) months prior to the July 1<sup>st</sup> rate effective date. Only audited or desk reviewed cost reports will be used in the rate setting process. New cost report information will be brought into the rate setting process on a periodic basis. The cost report information used to establish the operating and direct health care medians, and ultimate prices, will be rebased no less frequently than once every two (2) years.

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- f. **Minimum Direct Care Staffing Requirement** – In the event that a nursing facility does not incur direct care cost, at least equal to 94% of the direct care median, the Department will have the option to recoup from future Medicaid payments to that provider an amount equal to 100% of the difference between the provider's direct care rate and the actual cost the provider incurred. This provision is intended to encourage adequate direct care staffing.

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- g. **Rate Add-On to Reflect Changes in State / Federal Laws** – The Medicaid director can make adjustments to the operating price to reflect changes in state or federal laws, rules or regulations that have yet to be reflected in the base period cost report data.

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- h. **Budget Adjustment Factor** – In the event that the reimbursement system described in this section would result in anticipated payments to nursing facility providers being greater or less than the funding appropriated by the Nevada legislature, proportional increases or decreases will be made to the rates so that anticipated payments will equal legislative appropriations. This adjustment to rates will be made as a percentage increase or decrease in each provider's rate. The percentage will be determined in accordance with the following fraction:  $(\text{Legislative appropriations} / (\text{The Sum of Each Facility's Calculated Rate Multiplied by Each Facility's Proportional Share of the Anticipated (Budgeted) Case Load for All Freestanding Nursing Facilities}))$ . Medicaid days from the cost reports used in rate setting will be the basis for the proportional allocation of anticipated case load across all freestanding facilities.

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C. Cost Reporting Requirements:

1. Hospital-based and free-standing nursing facilities must complete and file an annual cost report with the Medicaid program. Cost and other statistical information within the cost report must be reported in compliance with allowable and non-allowable cost definitions contained in the Medicare/Medicaid provider reimbursement manual (commonly referred to as HIM 15).
2. Free-standing nursing facility cost reports are to be received by the Medicaid program by the last day of the third month following a facility's fiscal year end. If the facility is unable to complete their cost report within this time frame, a request for a 30 day extension can be requested from the Medicaid program (Division of Health Care Financing and Policy) prior to the original cost report due date. Reasonable extension requests will be granted.
3. Hospital-based nursing facility cost reports are to be filed with the Medicaid program following the cost report filing deadlines adopted by the Medicare program. If a facility requests an extension from the Medicare program, they must also request an extension from the Medicaid program (Division of Healthcare Financing and Policy). Extension requests approved by Medicare will automatically be approved by the Medicaid program, once the Division of Health Care Financing and Policy receives evidence of Medicare approval from the facility.
4. Facilities failing to file a Medicaid cost report in accordance with these provisions may have their payments suspended, or be required to pay back to the Medicaid program all payments received during the fiscal year period upon which they were to provide a cost report. Facilities may also be subject to late filing fees assessed in accordance with guidelines issued pursuant to the Medicaid Services Manual.

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D. New Facilities and Change of Ownership:

1. New facilities are those entities whose beds have not previously been certified to participate in the Medicaid program. New free-standing facilities will be reimbursed an interim rate computed from the following Nursing Facility rate components in effect on the date of the facility's Medicaid certification:
  - a. The Fair Rental Value per diem will be determined based upon an initial capital survey the new provider completes and submits to the Division of Health Care Financing and Policy, and upon the methodology described in section B.3.c. of this attachment.
  - b. The operating component for the rate will be the 'Operating Statewide Price' as described in section B.3.a. of this attachment.
  - c. The direct health care component will be the 'Statewide Direct Health Care Price' as described in section B.3.b. of this attachment.
  - d. The 'Budget Adjustment Factor', as described in section B.3.h. of this attachment, will be applied to determine the Facility Medicaid Rate.

This interim rate will be paid until such time that the rate is rebased under the provisions of Section B.3.e of this attachment.

2. New hospital-based facilities will receive an interim rate equal to the average rate (expressed as a percent of charges) paid to all other hospital-based nursing facilities effective at the start of the state fiscal year in which the facility began providing services to Medicaid recipients.
3. A change of ownership exists if the beds of the new owner have previously been certified to participate in the Medicaid program under the previous owner's provider agreement. Rates paid to free-standing nursing facilities that have undergone a change of ownership will be based upon the base rate and acuity data of the previous owner. The new owner's acuity data will be used to adjust the facility's rate following the rate adjustment schedule discussed in this rule. Facilities (hospital-based and free-standing) that undergo a change in ownership are required to file a closing cost report for the seller within 45 days of the date of sale. A new cost reporting period for the buyer will start on the effective date of the transaction. The interim rate paid to a new hospital-based owner will be the same interim rate the prior owner was receiving.

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D. Case Mix Index Calculation (Free-standing Nursing Facilities Only):

1. The Resource Utilization Group III (RUG-III) Version 5.12b, 34 group, index maximization model shall be used as the resident classification system to determine the case mix index (CMI) from data submitted from each facility on the Minimum Data Set (MDS) resident assessments. The case mix indexes assigned to each of the 34 classification groups will be developed using the 1995-1997 time study minutes and will use relative wage rates of 2.0 for RN time, 1.5 for LPN time and 1.0 for nurse aide time.
2. Each nursing facility resident in a facility, with a completed and submitted MDS 2.0 shall be assigned to a RUG-III classification group on the first day of each calendar quarter. These RUG-III assignments will be based upon each resident's most current MDS assessment available on the first day of each calendar quarter. Using the facility's simple average of the individual residents' case mix indexes, two case mix indexes (CMIs) will be calculated for the facility. One being a facility wide CMI, which will be based upon all of the facility's residents, and the other being the Medicaid CMI, which will be calculated using only the Medicaid residents for each facility. Both of these average case mix indexes will be rounded to four decimal places.

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**F. Special Care Rates:**

1. The Division of Health Care Financing and Policy shall establish special care rates for recipients ages 21 and over that are ventilator dependent, or behaviorally complex, and pediatric recipients less than 21 years of age with special high cost care needs and/or who are ventilator dependent. These special care rates will be all-inclusive per diem rates based on the costs of providing services to recipients.
  - a. The per diem rate for recipients ages 21 and over that are ventilator dependent is the facility-specific fair rental value per diem, as computed under section B.3.c. of this attachment, plus an add-on of \$500.00. The ventilator dependent add-on rate is the rounded average of the sum of the daily average ancillary costs plus the skilled nursing level 3 rate in effect as of October 1, 2001 for this recipient population.
  - b. The per diem rate for behaviorally complex recipients is the facility-specific per diem rate plus an add-on of \$261.29. The behaviorally complex add-on rate is the starting hourly wage plus benefits for a certified nursing assistant employed by the State of Nevada for 22 hours per day adjusted for a staff to patient ratio of 1 to 1.25.
  - c. The per diem rate for recipients less than 21 years of age is the facility-specific fair rental value per diem, as computed under section B.3.c. of this attachment, plus an add-on of \$475.00. The pediatric add-on rate is the rounded average of the sum of the daily average ancillary costs plus the skilled nursing level 3 rate in effect as of October 1, 2001 for this recipient population.
  - d. The per diem rate for recipients less than 21 years of age that are ventilator dependent is the facility-specific fair rental value per diem, as computed under section B.3.c. of this attachment, plus an add-on of \$600.00. The pediatric add-on rate is the rounded average of the sum of the daily average ancillary costs plus the skilled nursing level 3 rate in effect as of October 1, 2001 for this recipient population.
2. The Division of Health Care Financing and Policy shall establish all-inclusive per diem special care rates for Medicaid recipients with unique high cost care needs when necessary to avoid out-of-state nursing facility placements. Nursing facilities may not bill the Medicaid program for special care recipients other than on a per diem basis using the established special care rate. Rates will address the following client care issues:
  - a. Patient's acuity
  - b. Availability of beds
  - c. Patient's freedom of choice
3. When special care rates are required or when multiple facilities are equally acceptable under F.2. above, the nursing facility with the lowest per diem rate will be selected. The per diem rate will not exceed the facility's usual and customary rate for similar services.

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G. Nurse Aide Training Cost:

Nursing facilities are required to reimburse certified nurses aides (CNAs) if the CNA paid for the training within one year of being employed by the facility and has not previously been reimbursed. The amount nursing facilities are required to reimburse the CNA is limited to the cost of the class and books at Nevada community colleges. The aide is to be reimbursed after three months of employment in the facility. Nursing facilities must follow the procedures specified by Nevada Medicaid to receive reimbursement from Medicaid for their share of the amount paid to the CNA. Facilities which conduct a training program will continue to bill Medicaid for the cost of the training and competency evaluation.

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H. Intermediate Care Facilities for the Mentally Retarded (ICFs/MR):

1. ICFs/MR (state-operated):

- a. ICFs/MR, excluding non state-operated ICFs/MR, are reimbursed under Medicare principles of retrospective reimbursement described in 42 CFR 413 and further specified in HCFA Publication 15.
- b. In no case may payment exceed audited allowable costs.
- c. Interim rates will be based upon the most recent audited cost reports for the current state fiscal year. The interim rate for the initial year of operation will be based upon cost and utilization projections.
- d. Each facility is paid the lower of 1) billed charges; or 2) an interim rate subject to settlement in accordance with a. through c. above.

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2. ICFs/MR (non state-operated):

- a. Prospective Payment Rate: Non state-operated ICFs/MR-Small ("small" is defined as facilities having six beds or less) will be paid a prospective payment rate for basic service costs, other than day training costs and property costs, on a per patient day basis. Day training costs and property costs, excluded from the basic prospective rate, will be reimbursed under Medicare principles of retrospective reimbursement as described in paragraph 1 above.
1. The initial basic prospective payment rate per patient day will be the average of costs (excluding residential staff wages and benefits) of the four private ICFs/MR-Small operating a full year, from 1993 audited cost reports. Costs will be indexed to the common time period of December 31, 1993. Residential staff wages and benefits cost is calculated, and added to the average, at the rate of \$11 per hour for 6.4 full-time equivalents. The initial rate period is one year from July 1, 1995 through June 30, 1996. Therefore, the rate will be adjusted for inflation for the period June 30, 1993 - December 31, 1995 (the midpoint of the cost report period to the midpoint of the rate period) by the percentage change in the Consumer Price Index - All Urban and Clerical Workers (CPI), for calendar year 1993 times 2.5. The initial rate will be effective for private ICFs/MR-Small on July 1, 1995.
  2. Rates in effect March 31, 2002, will be continued without adjustment. When rebasing, costs will be indexed to a common point in time, arrayed from highest to lowest, and the cost of the 60<sup>th</sup> percentile facility selected. The rate will further be adjusted for inflation by the CPI. Only audited cost reports of private facilities completed by March 31<sup>st</sup> of the same year will be used.
  3. In addition, the rate will be adjusted for increased costs of services over basic inflation resulting from new federal or state guidelines.
  4. Day training costs must be approved by the Division of Mental Health Developmental Services (MHDS). These approvals must be obtained annually on all patients and anytime there is an increase in service cost.
  5. Property costs consist of a property lease (or in the case of an owned facility, interest and depreciation) as well as depreciation of equipment, property insurance and property taxes.
- b. Prospective Payment Rate: Non state-operated ICFs/MR-Large ("large" is defined as facilities having more than six beds) will be paid the lower of 1) billed charges; or 2) an all-inclusive prospective per diem rate equal to the interim rate in effect at December 31, 2003..
1. These all-inclusive rates will be effective for services rendered after December 31, 2003, until the rates are rebased as directed by the Department of Human Resources.

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I. Swing-bed hospitals:

1. Inpatient hospital services furnished by a certified swing-bed hospital which have been certified by the Peer Review Organization for payment at the nursing facility level are reimbursed in accordance with 42 CFR 447.280.
2. Average statewide weighted per diem payments for all nursing facility routine services (excluding ICF/MR) are calculated for a calendar year; each rate is rounded to the nearest even dollar and becomes the swing-bed rate for routine nursing facility services provided in the subsequent calendar year. Swing-bed rates are not subject to later adjustment.
3. Ancillary services required by swing-bed patients are separately payable as "outpatient hospital services;" see Attachment 4.19-B, Item 2.a.

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STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

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J. Out-of-state nursing facilities and ICF/MRs:

Out-of-state nursing facilities and ICF/MRs are reimbursed according to the following:

1. The same rate that the facility is reimbursed by its own state Medicaid program (rounded up to the nearest dollar);  
or
2. A per diem rate may be negotiated when the following client care issues are such that the rate in J.1. is insufficient to provide placement:
  - a. Patient's acuity
  - b. Availability of beds
  - c. Patient's freedom of choice
3. When negotiation is required or when multiple facilities are equally acceptable under J.1. & 2. above, the out-of-state nursing facility or ICF/MR with the lowest per diem rate will be selected. The per diem rate will not exceed the facility's usual and customary rate for similar services.

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K. Nevada State Veterans Nursing Home:

1. The Nevada State Veterans Nursing Home is reimbursed under Medicare principles of retrospective reimbursement described in 42 CFR 413 and further specified in CMS (HCFA) Publication 15.
2. In no case may payment exceed audited allowable costs.
3. For cost reporting periods prior to November 30, 2004, Medicaid reimbursement will be less any per diem payments received by the Home from the Veteran's Administration, payments from the recipient, or other third party payments. For cost reporting periods on or after November 30, 2004 Medicaid reimbursement will not be reduced by any per diem payments received by the Home from the Veteran's Administration, but will be less payments from the recipient, or other third party payments.
4. Interim rates will be based upon the most recent audited cost reports for the current state fiscal year. The interim rate for the initial year of operation will be based upon cost and utilization projections.
5. The Home is paid at the lower of 1) billed charge; or 2) an interim rate subject to settlement in accordance with 1. through 3. above.

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